Weill Cornell Medicine

Weill Cornell Center for Sleep Medicine
425 East 61st Street, 5th Floor, New York, NY 10065
Telephone: 646-962-7378 / Fax: 646-962-0455
Web: www.weill.cornell.edu/sleepcenter

Sleep Questionnaire

Today's date: ____/____/_____ MR#_____

Patient name: _____ Age: _____ DOB: ____/____/_____

Marital status: _____ Gender: M F Height:____ft_____in Weight:_____ lbs

Ethnicity: _____ Referred by:_____

Reason for the visit: □ Insomnia □ Sleep apnea □ Other: _____
Have you been previously evaluated for a sleep disorder? □ No □ Yes
Have you ever had an overnight sleep study? □ No □ Yes

I. EPWORTH

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Never	Slight	Moderate	High	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting inactive in a public place (example: a theater or meeting)
☐	☐	☐	☐	As a passenger in a car for 1 hour without a break
☐	☐	☐	☐	Lying down to rest in the afternoon when circumstances permit
☐	☐	☐	☐	Sitting and talking to someone
☐	☐	☐	☐	Sitting quietly after lunch without alcohol
☐	☐	☐	☐	In a car (driving) while stopped for a few minutes in traffic

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II. Questionnaire:

Do you snore? □ No □ Yes □ Don't know

Your snoring is: □ Slightly louder than breathing □ As loud as talking □ Louder than talking □ Very loud

Has your snoring ever bothered other people? □ No □ Yes

Do you have high blood pressure, or take medication for high blood pressure? □ No □ Yes

Please check the appropriate box :	Nearly every day	3-4 times a week	1-2 times a week	1-2 times a month	Never or nearly never
How often do you snore?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Has anyone noticed that you quit breathing during your sleep?	1 ☐	2 ☐	3 ☐	4 ☐	5☐
During your wake time, do you feel tired, fatigued or not up to par?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Have you ever nodded off or fallen asleep while driving a vehicle? □ No □ Yes					
If yes, how often does it occur?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Do you have headaches after waking up?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Do you have a dry mouth at night?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

III. Sleep Habits – *Please answer questions based on an average night of sleep*:

	Bedtime	Time to fall asleep	Wake time	Out of bed time	Approximate sleep duration
Weekdays:	_____ AM/PM	_____ min	_____ AM/PM	_____ AM/PM	_____ hours
Weekends:	_____ AM/PM	_____ min	_____ AM/PM	_____ AM/PM	_____ hours

Do you consider yourself a night owl? □ No □ Yes

Do you consider yourself a morning person? □ No □ Yes

Do you take medication or a supplement to help you sleep? □ No □ Yes: _____Dose:_____

Do you need an alarm clock to wake up in the morning? □ No □ Yes

How many naps do you take per week? _____ What is the average duration of each nap? _____

Are these naps refreshing? □ No □ Yes Do you dream during naps? □ No □ Yes

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Check the answer that best describes how often you experience each situation:	*Never*	*Less than 2 times a week*	*2-4 times a week*	*At least 5 times a week*
Taking sleeping pills to help you sleep	1 ☐	2 ☐	3 ☐	4 ☐
Having trouble falling asleep	1 ☐	2 ☐	3 ☐	4 ☐
Having very restless sleep	1 ☐	2 ☐	3 ☐	4 ☐
Waking up several times at night	1 ☐	2 ☐	3 ☐	4 ☐
Having trouble getting back to sleep	1 ☐	2 ☐	3 ☐	4 ☐
Waking up earlier than you wanted to	1 ☐	2 ☐	3 ☐	4 ☐
Waking up in the morning unrefreshed	1 ☐	2 ☐	3 ☐	4 ☐
Feeling sleepy despite adequate sleep	1 ☐	2 ☐	3 ☐	4 ☐
Feeling fatigued despite adequate sleep	1 ☐	2 ☐	3 ☐	4 ☐

Do you have unusual behaviors during sleep? □ No □ Yes

If yes: □ Nightmares □ Sleepwalking □ Bedwetting □ Other:_____

Do you grind or clench your teeth at night? □ No □ Yes If yes, do you use a dental guard? □ No □ Yes

Have you ever been told by others that you act out your dreams? □ No □ Yes

Have you ever felt paralyzed when you first wake up or when you are falling asleep? □ No □ Yes

Have you ever experienced episodes of muscle weakness, loss of muscle strength or limp muscles in any part of your body during the following situations:

- When you laugh □ No □ Yes
- When you are angry □ No □ Yes
- When hearing or telling a joke □ No □ Yes
- When tense or under stress □ No □ Yes

Have you ever had the sensation of seeing or hearing things when waking up or falling asleep? □ No □ Yes

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IV. RLS - *Please check the appropriate box:*

Do you kick your legs at night, prior to or during sleep? □ No □ Yes
Do you ever experience a desire to move your legs due to discomfort or disagreeable sensations in your legs? □ No □ Yes
Do you sometimes feel the need to move to relieve the discomfort, for example by walking or rubbing your legs? □ No □ Yes
Are these symptoms worse later in the day or at night? □ Not applicable □ No □ Yes
Are these symptoms worse when you are at rest, with at least temporary relief by activity? □ Not applicable □ No □ Yes

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V. CPAP *(for CPAP users only - skip this section if you do not use CPAP):*

How many nights per week do you use your CPAP? _____ nights/week
How many hours per night do you use your CPAP? _____ hours/night

While using CPAP, are any of the following problems present?

□ Snoring	□ Dry mouth/dry nose	□ Mask marking the face
□ Gasping or choking	□ Stuffy or running nose	□ Bridge of nose discomfort
□ Witnessed apnea	□ Ear pain/ear popping	□ Skin sore or acne from mask
□ Unrefreshing sleep	□ Irritated, dry or red eyes	□ Machine noise

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VI. SOCIAL HABITS: Profession/Job: _____

Occupational Status: □ Actively working □ Retired □ Disabled □ Shift worker

Are you sedentary (no more than 10 minutes of uninterrupted physical activity) during the day? □ No □ Yes
Do you exercise for more than 30 minutes at least two times a week? □ No □ Yes

Do you smoke or have you ever smoked? □ No □ Yes
If so, how many cigarettes a day?_____ For how long?_____
If you quit smoking, how long ago did you quit?_____

How many cups of coffee do you drink each day? _____

How many ounces of other caffeinated beverage (e.g. soda, tea, energy drinks) do you drink a day? _____

Do you think you are sensitive to caffeine? □ No □ Yes

Do you drink alcoholic beverages? □ No □ Yes Types of drinks: _____ Amount: _____per week/day

Do you use any recreational drugs? □ No □ Yes □ Decline to answer

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VII. Family History - *Please check the box if you have more than 1 family members with the following:*

☐ Sleep Apnea ☐ Restless Legs ☐ Night type ☐ Morning type ☐ Narcolepsy

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VIII. Medications - *Please check the box if you take any of the following medications on a regular basis:*

☐ Aspirin	☐ Blood pressure pills	☐ Insulin
☐ Cholesterol pills	☐ Sedatives	☐ Oxygen
☐ Blood thinners	☐ Tylenol, Advil, painkillers	

☐ Sleep medications (name): _____

Other medications and dosage:_____

_____

_____

Please list any allergies: _____□ none known
Please list any major surgeries you have had: _____

IX. Review of Systems - *Please check the appropriate box for a medical problems or symptom that you have*:

□ Weight gain: _____ lbs □ Weight loss: _____ lbs	□ High blood pressure □ Stent (cardiac)/bypass	□ Itching/ skin problems □ Allergies
□ Previous head or facial trauma □ Headaches □ Lack of energy	□ Heart failure □ Heart attack □ Cardiac arrhythmia	□ Easily bruised □ Anemia □ Thrombosis
□ Previous nasal fractures □ Mandibular fracture □ Sinus problems □ Nasal polyps □ Chronic rhinitis/postnasal drip □ Problems with nasal breathing	□ Irregular heart beat/palpitations □ Pacemaker □ High cholesterol □ Leg edema □ Shortness of breath	□ Seizure disorder □ Stroke/TIA □ Blurred/double vision □ Ringing or buzzing in ears □ Loss of memory □ Loss of balance
□ Removal of tonsils/adenoids □ Increased neck size □ Bumps or nodes on your neck	□ GERD/heartburn □ Peptic ulcers □ Bowel problems/colitis	□ Anxiety □ Depression □ Suicide attempts
□ Wheezing □ Asthma, COPD or emphysema □ Arthritis/joint aches □ Back pain/ Muscle aches	□ Diabetes or high blood sugar □ Thyroid problems □ Kidney failure □ Night-time urination	□ Prostate problems *(men only)* *For women only:* □ Currently pregnant □ Irregular menstrual periods □ Menopausal
□ Cancer – type:_____		

X. Research Information

The Weill Cornell Medical College Center for Sleep Medicine is committed to excellence in research, teaching, patient care, and the advancement of the art and science of medicine. Part of our mission is to conduct cutting edge research in order to improve the health care of the nation and the world both now and for future generations, and to provide the highest quality of clinical care for our patients. Data collected from patients may be used in an unidentified manner to conduct quality performance assessments and exploratory research analyses. As a patient of the Center for Sleep Medicine you may be eligible to participate in some of the on-going research efforts. If you would like to hear more about our studies and consider participating in a research study conducted by our Center, please check the appropriate box. Please note that the Center will never use your private health information without your express consent.

☐ Yes, I allow the Center's staff to contact me regarding potential research studies in the future. This does not represent any commitment from my part to participating in research.

☐ No, I would not like to be contacted about research studies

_____ _____ _____

Name (printed) Signature Date

Diagnoses: _____ _____ _____

(Primary) (Secondary) (Tertiary)

Plan:_____

Clinician's signature: _____ Date: _____